SERFF Tracking Number:	*AENX-126196155*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*42687*
Company Tracking Number:	*AH AR0110501F01*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*2009 Individual*		
Project Name/Number:	*2009 Individual/AH AR0110501F01*		

Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2009 Individual	SERFF Tr Num: AENX-126196155	State: ArkansasLH
TOI: H16I Individual Health - Major Medical	SERFF Status: Closed	State Tr Num: 42687
Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)	Co Tr Num: AH AR0110501F01	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: SPI AetnaSPI	Disposition Date: 06/19/2009
	Date Submitted: 06/18/2009	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name: 2009 Individual	Status of Filing in Domicile:
Project Number: AH AR0110501F01	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 06/19/2009	Explanation for Other Group Market Type:
	State Status Changed: 06/19/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

Revised summary of coverage for Individual advantage plans

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*AENX-126196155*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*42687*
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Product Name:	*2009 Individual*		
Project Name/Number:	*2009 Individual/AH AR0110501F01*		

John Ciesielski, Product and Regulatory Affairs Manager
CiesielskiJW@Aetna.com
151 Farmington Avenue
Hartford, CT 06156
(860) 279-1282 [Phone]
(860) 952-2069[FAX]

Filing Company Information

Aetna Life Insurance Company	CoCode: 60054	State of Domicile: Connecticut
151 Farmington Avenue	Group Code: 1	Company Type:
Hartford, CT 06156	Group Name: Aetna	State ID Number:
(860) 273-7546 ext. [Phone]	FEIN Number: 06-6033492	

SERFF Tracking Number:	*AENX-126196155*	*State:*	*Arkansas*
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Product Name:	*2009 Individual*		
Project Name/Number:	*2009 Individual/AH AR0110501F01*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	$50.00	06/18/2009	28668728

SERFF Tracking Number:	*AENX-126196155*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/19/2009	06/19/2009

SERFF Tracking Number:	*AENX-126196155*	*State:*	*Arkansas*
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Product Name:	*2009 Individual*		
Project Name/Number:	*2009 Individual/AH AR0110501F01*		

Disposition

Disposition Date: 06/19/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AENX-126196155*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*42687*
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Product Name:	*2009 Individual*		
Project Name/Number:	*2009 Individual/AH AR0110501F01*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Explanation of variable	Approved-Closed	Yes
Supporting Document	redline copy	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Form	Summary of coverage	Approved-Closed	Yes

SERFF Tracking Number:	*AENX-126196155*	*State:*	*Arkansas*
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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GR-11741-SOC 06/09	Certificate Amendment, Insert Page, Endorsement or Rider	Summary of coverage	Initial		0	GR-11741-SOC 06_09.PDF

Summary of Coverage

This Summary of Coverage is attached to and forms part of your Policy. The benefits shown in this Summary of Coverage are available for the persons listed in the Policy.

Health Expense Coverage For You and Your Dependents

The Policy spells out the period to which each maximum applies. These benefits apply separately to each covered person. All maximums included in this Policy are combined maximums between Preferred and Non-Preferred Care, unless stated otherwise. Read the coverage section in your Policy for a complete description of the benefits payable.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the Policy:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

Comprehensive Medical Expense Coverage

Utilization and Preservice Review Procedures

Certain procedures, admissions, services, supplies and treatments and certain other types of care must be certified as necessary if full benefits are to be available under the Policy.

The Policy lists the procedures, services, supplies and treatments which must be certified, describes the other types of care affected and gives you details on how to obtain certification and avoid a reduction in benefits payable.

Certification for Certain Procedures/Treatments Excluded Amount: [$400].

The Benefits Payable

After any applicable deductible, the Health Expense Benefits payable under this Policy in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be described later in the Policy. Benefits may vary depending upon whether a Preferred Care Provider is utilized. A Preferred Care Provider is a health care provider who has agreed to provide services or supplies at a "negotiated charge." A copy of a Directory which lists these health care providers is available on-line at www.aetna.com/docfind/custom/advplans, or may be requested by calling 866-565-1236.

[Deductible Amounts

	Individual	Family
Calendar Year Deductible:		
Preferred Care	[$0-8,000]	[$0-24,000]
Non-Preferred Care	[$500-10,000]	[$1,000-30,000]

[[The Calendar Year Deductible applies separately to Preferred and Non-Preferred Care Expenses.] [The Calendar Year deductible is not applicable to Preferred Care expenses.] [The Calendar Year deductible is not applicable to Preferred Care only for:

Urgent Care Facility
Infusion Therapy Home or Physician Office
Infusion Therapy Outpatient Facility
Physician's services for office visits to Non-Specialists
Physician's services for office visits to Specialists
Preventive Health Expenses
Routine screening for cancer expenses
Gynecological Examinations/Mammograms
Hearing Aids
Generic Drugs

[Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the Calendar Year.]

[Once [2, 3] members of the family each meet their individual Calendar Year deductibles, from then on each other member of the family will be considered to have met their deductible for that Calendar Year.]

[A separate deductible applies to prescription drugs and medicines.]]]]

[Inpatient Hospital Copay and Deductible

[An Inpatient Hospital **Copayment** is an amount you are required to pay when you or a covered dependent is confined as an inpatient in a **hospital**. A **copayment** is a specified dollar amount required to be paid by you at the time you receive a covered service from a **[preferred] provider**.

[An Inpatient Hospital **Deductible** is a specified dollar amount for which no benefit is paid when you or a covered dependent is confined as an inpatient in a **hospital**.]

These Inpatient Hospital [**copayments]** [and] [**deductibles]** are in addition to any other [**copayments] [**and] **[deductibles**] applicable under this plan. They apply to each confinement as an inpatient in a **hospital.** If your confinement as an inpatient in a **hospital** is separated by less than 48 hours (regardless of cause), only one Inpatient Hospital [**copayment]** [or] [**deductible]** will apply. Not more than three Inpatient Hospital [**copayments]** [or] [**deductibles**] will apply for each facility type during a [calendar] year.]

[Covered expenses applied to the Inpatient Hospital deductible cannot be applied to any other **deductible** required in your plan. Likewise, covered expenses applied to your plan's other **deductibles** cannot be applied to meet the Inpatient Hospital deductible].]

If shown in your Summary of Coverage, this is the amount of Inpatient Hospital expenses you pay for each **Hospital** confinement of a Covered Person. Not more than 3 Inpatient Hospital Deductibles will apply to all confinements of a Covered Person in any one calendar year.

The Inpatient Hospital Deductible will only be applied once to all **Hospital** confinements, regardless of cause, which are separated by less than 10 days.

Expenses used to meet the Inpatient Hospital Deductible cannot be used to meet any other applicable **Deductible**. Expenses used to meet any other applicable **Deductible** cannot be used to meet the Inpatient Hospital Deductible.

Calendar Year **Deductible**

This is the amount of Covered Medical Expenses you pay each calendar year before benefits are paid. There is a calendar year Deductible that applies to each Covered Person.

Hospital Emergency Room **Copay**

A separate Hospital Emergency Room **Copay** applies to each visit for emergency care, by a Covered Person in a **Hospital**'s emergency room unless the Covered Person is admitted to the **Hospital** as an inpatient within 24 hours after a visit to a **Hospital** emergency room.]

[Individual Deductible
The individual **deductible** is the amount of [**Preferred**] [**Non Preferred**] covered expenses you must incur in a [calendar] year before benefits are paid. For purposes of this plan, an individual means a single covered person enrolled for self only coverage.]

[**Family Deductible**
The family **deductible** is the amount of [**Preferred**] [or] [**Non Preferred**] covered expenses that you and your covered dependents must incur in a [calendar] year before benefits are paid during the [calendar][plan] year for any family members. For purposes of this plan, a family means a covered person enrolled with one or more dependents. The family **deductible** can be met by one family member, or a combination of family members.]

[Covered expenses that are subject to the d**eductible** include **prescription drug**, dental, vision and hearing expenses provided under the [Medical] [**Prescription drug**] [Dental] [Vision] [Hearing] Plans.]

If any expense is covered under one type of Covered Medical Expense, it cannot be covered under any other type.

Payment Percentage

The Payment Percentage applies after any copay or deductible amounts, unless otherwise specified above.

Preferred Care		**Non-Preferred Care**
For Hospital Expenses		
Inpatient Coverage		
[50-100%]		[50-100%]
	or	
[$0-100 inpatient hospital copay, thereafter 50-100%]		[$0-200 inpatient hospital deductible after calendar year deductible, thereafter 50-100%]
Outpatient Coverage		
[50-100%]		[50-100%]
	or	
[$0-100 per visit copay, thereafter 50-100%] **[(Waived if admitted)]**		[$0-200 per visit deductible after calendar year deductible, thereafter 50-100%]

Preferred Care	**Non-Preferred Care**
Emergency Room [50-100%] **or** [$0-400 per visit copay, thereafter 50-100%] **[(Waived if admitted)]**	[50-100%] [$0-400 per visit deductible thereafter 50-100%]
Urgent Care Facility [50-100%] Or [$0-100 per visit copay, thereafter 50-100%]	[50-100%]
Skilled Nursing Facility Expenses* [50-100%] * In lieu of hospital.	[50-100%]

Preferred Care and **Non-Preferred Care** Calendar Year Maximum: [30-120] days

Home Health Care Expenses* [50-100%] *In lieu of hospital.	[50-100%]

Preferred Care and **Non-Preferred Care** Calendar Year Maximum: [30-60] visits

§ **Infusion Therapy** *Home or Physician Office* [$0-50 copay per visit, thereafter 50-100%]	[50-100%]
Infusion Therapy *Outpatient Facility* [50-100%]	[50-100%]

*Applicable to non preferred care: administration, nursing, equipment, supplies-the maximum benefit of [$0 -$50] per visit and amounts over allowable do not apply to the Payment Limit. Drugs are paid according to **Recognized Charge** [50-100%].

Hospice Expenses [50-100%]	[50-100%]

Preferred Care and **Non-Preferred Care** Lifetime Maximum: [$10,000]

Outpatient Surgical Expenses [50-100%]	[50-100%]

Physicians' Services

Office Visits (non-surgical) to Non-Specialist (internist, general physician, family practitioner, or pediatrician).

Office Visits to Non-Specialists [$0-50 copay per visit for the first 1-5 visits, thereafter 50-100%] Or	[50-100%]

[$0-50 copay per visit, thereafter 70-100%]

Preferred Care	**Non-Preferred Care**
Office Visits to Specialists [$0-50 copay per visit for the first 1-5 visits, thereafter 50-100%] Or [$0-50 copay per visit, thereafter 70-100%]	[50-100%]
Other Physicians' Services [50-100%]	[50-100%]

Preventive Health Expenses

For Covered Dependent's to Age 18:

[$0-50 copay per visit, thereafter 100%]	[50-100%]

Preferred Care and **Non-Preferred Care** Maximum: [$200]

For Policyholder or the Covered Dependent's Age 18 or over:

[$0-50 copay per visit, thereafter 100%]	[50-100%]

Preferred Care and **Non-Preferred Care** Maximum: [$200]

Routine Screening for Cancer

For age and frequency limits applicable to Routine Cancer Screening coverage, refer to the Policy.

Gynecological Exams/Mammogram [$0-50 copay per visit, thereafter 70-100%]	[50-100%]
Other Cancer Screenings [100%]	[50-100%]

[Includes one annual screening mammogram; one routine gynecological exam per Calendar Year, including a Pap smear and related services; colorectal screening in accordance with the latest screening guidelines issued by the American Cancer Society; and one prostate antigen test (PSA) once each Calendar Year for males age 40 or older.]

[Prescription Drug Benefits (Out of Hospital)	
*[Retail and Mail Order Pharmacy]**	*[Retail and Mail Order Pharmacy]**
[$0-1,000] Individual Calendar Year deductible [(Not applicable to generic drugs).]	[$0-1,000] Individual Calendar Year deductible [(Not applicable to generic drugs).]
[Integrated Medical/RX deductible	Integrated Medical/RX deductible]
Generic Drugs [$0-50 copay per prescription or refill, thereafter 50-100%]	[$0-50 deductible per prescription or refill, thereafter 50-100%]
Formulary brand name drugs [50%] Or [$0-40] per prescription or refill	[$0-50 deductible per prescription or refill, thereafter 50-100%] [$0-50 deductible per prescription or refill, thereafter 50-100%]
[Not covered]	[Not covered]
[Non-formulary brand name drugs:] [50%] Or [$0-40] per prescription or refill	[$0-50 deductible per prescription or refill, thereafter 50-100%] [$0-50 deductible per prescription or refill, thereafter 50-100%]
[Not covered]	[Not covered]

Preferred Care and **Non-Preferred Care** Calendar Year Maximum: [$2,500]

*Not more than up to a [30-90] day supply from a participating pharmacy.
**Not more than up to a [30-90] day supply from a non-participating pharmacy.

*Mail Order Pharmacy****	*Mail Order Pharmacy*
[50-100%]	Not Covered

Preferred Care and **Non-Preferred Care** Calendar Year Deductible: [$0-1,000]

Copay: [2X-3X] the copay for Retail Pharmacy.

***Limited to not more than a [31-90] day supply.

Preferred Care	**Non-Preferred Care**
[[Self]-Injectables: The copay applicable to self-injectable drugs is described below. The benefit Percentage, Calendar Year Maximum and limitations as to supply amounts are the same as for other types of drugs from a Retail Pharmacy:	Not Covered
Initial prescription or refill	

Not on Formulary: [10-50%] of
The negotiated charge between Aetna
And the preferred pharmacy [vendor
or supplier designated by Aetna]

Preferred Care	**Non-Preferred Care**

On Formulary: [10-50%] of
The negotiated charge between Aetna
And the preferred pharmacy [vendor
or supplier designated by Aetna]

[The [Deductible amount] will not apply
to covered benefits for [chronic] [and]
[preventive] prescription drug expenses.

[These drugs include those used to treat
[hypertension, hyperlipidemia, diabetes,
asthma, osteoporosis, depression, and
heart disease]. The [chronic] [and]
[preventive] prescription drug list is
available upon request by the Covered Person
or may be accessed at the ALIC website,
at [www.aetna.com].
The list is subject to change]

Prescription Refill:
Not on Formulary: [10-50%] of
The negotiated charge between Aetna
And the preferred pharmacy [vendor
or supplier designated by Aetna]

On Formulary: [10-50%] of
The negotiated charge between Aetna
And the preferred pharmacy [vendor
or supplier designated by Aetna.]]]

Preferred Care	**Non-Preferred Care**

Durable Medical Equipment

[50-100%]	[50-100%]

Preferred Care and **Non-Preferred Care** Annual Maximum: [$1,000-5,000]

Professional Ambulance Expenses

[50-100%]	[50-100%]

Preferred Care and **Non-Preferred Care** Per Trip Maximum: [$1,000-5,000]

Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Therapy and Spinal Manipulation

[50-100%]	[50-100%]

Preferred Care and **Non-Preferred Care** Per Visit Maximum: [$0-25]
Preferred Care and **Non-Preferred Care** Calendar Year Maximum Visits: [24]
Preferred Care and **Non-Preferred Care** Calendar Year Maximum: [$600]

Pregnancy Coverage

[50-100%] [50-100%]

Preferred Care and **Non-Preferred Care** [$0-2,000] copayment per inpatient hospital maternity related admission.

[Mental Health DRAFTING NOTE: OMIT IF NO STATE MANDATE
[50-100%] [50-100%]
[Not Covered]]

[Hearing Aid
One hearing aid per ear every 36 months up to $200 per hearing aid (includes repairs). Batteries and auxiliary equipment are excluded. [Deductible and coinsurance do not apply.] Not covered for first 12 months.]

Organ Transplants
[50-100%] [50-100%]
[Not Covered]

All Other Covered Medical Expenses
The Payment Percentage shown below as to all other covered medical expenses not specified above:
[50-100%] [50-100%]

Payment Limits
These limits apply to Covered Medical Expenses. [These limits apply separately to Preferred and Non-Preferred Care.] [Expenses which are Excluded Amounts for failure to precertify certain procedures/treatments, NOTE: OMIT IF PREGNANCY NOT MANDATED [expenses which are applied to any Pregnancy and Maternity Benefits copay amounts,]and expenses that apply to copay amounts for other expenses] will not count toward these limits.

Payment Limit which Applies to Expenses for a Covered Person
When a Covered Person's Covered Medical Expenses for which no benefits are paid reach [$2,000-12,500] in a Calendar Year, benefits will be payable at 100% for all of the Covered Person's Covered Medical Expenses to which this limit applies and which are incurred during the rest of that Calendar Year.

Payment Limit which Applies to Expenses for a Family
When a family's Covered Medical Expenses for which no benefits are paid reach [$4,000-37,500] in a Calendar Year, benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred during the rest of that Calendar Year.

[Payment Limit which Applies to Expenses for a Covered Person
When a Covered Person's Covered Medical Expenses for which no benefits are paid reach [$2,000-12,500] in a Calendar Year for Preferred Care and [$2,000 -12,500] in a Calendar Year for Non-Preferred Care, benefits will be payable at 100% for all of the Covered Person's Covered Medical Expenses to which this limit applies and which are incurred during the rest of that Calendar Year.]

[Payment Limit which Applies to Expenses for a Family

When a family's Covered Medical Expenses for which no benefits are paid reach [$4,000 -37,500] in a Calendar Year for Preferred Care and [$4,000-37,500] in a Calendar Year for Non-Preferred Care, benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred during the rest of that Calendar Year.]

Private Room Limit The institution's semiprivate rate.

Lifetime Maximum Benefit [$25,000-5,000,000]
Note: Lifetime Maximum cross applies to preferred and non preferred care

Adjustment Rule

If, for any reason, a Covered Person is entitled to a different amount of coverage, coverage will be adjusted as of its effective date.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised Policy provisions. In other words, there are no vested rights to benefits based upon provisions of this Policy in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under the Policy. Requests for amounts of coverage other than those to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

The insurance described in this Summary of Coverage will be provided under Aetna Life Insurance Company Policy Form GR-11741.

KEEP THIS SUMMARY OF COVERAGE WITH YOUR POLICY

SERFF Tracking Number:	*AENX-126196155*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*42687*
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TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*2009 Individual*		
Project Name/Number:	*2009 Individual/AH AR0110501F01*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AENX-126196155*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*42687*
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Product Name:	*2009 Individual*		
Project Name/Number:	*2009 Individual/AH AR0110501F01*		

Supporting Document Schedules

Bypassed -Name: Flesch Certification
Bypass Reason: not applicable
Comments:
Review Status: Approved-Closed 06/19/2009

Bypassed -Name: Application
Bypass Reason: not applicable
Comments:
Review Status: Approved-Closed 06/19/2009

Bypassed -Name: Health - Actuarial Justification
Bypass Reason: rates filed under separate cover
Comments:
Review Status: Approved-Closed 06/19/2009

Bypassed -Name: Outline of Coverage
Bypass Reason: not applicable
Comments:
Review Status: Approved-Closed 06/19/2009

Satisfied -Name: Cover Letter
Comments:
Cover letter
Attachment:
Cover Letter.PDF
Review Status: Approved-Closed 06/19/2009

Satisfied -Name: Explanation of variable
Comments:
Explanation of variable
Review Status: Approved-Closed 06/19/2009

SERFF Tracking Number:	*AENX-126196155*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*42687*
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Attachment:

Explanation of variable.PDF

SERFF Tracking Number:	*AENX-126196155*	*State:*	*Arkansas*
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Product Name:	*2009 Individual*		
Project Name/Number:	*2009 Individual/AH AR0110501F01*		

Satisfied -Name: redline copy

Review Status: Approved-Closed 06/19/2009

Comments:
redline copy

Attachment:
redline copy.PDF

Satisfied -Name: AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT

Review Status: Approved-Closed 06/19/2009

Comments:

Attachments:
AR - NAIC TRANSMITTAL DOCUMENT.PDF
AR - NAIC FORM FILING ATTACHMENT.PDF

June 18, 2009

Insurance Commissioner Jay Bradford
Compliance - Life and Health
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: Form Filing - 2009 IND- 2009 Individual Product Refresh (ALIC)
Accident and Health
Company Filing#: AH AR0110501F01
Aetna Life Insurance Company NAIC#: 001-60054 FEIN#: 06-6033492

Dear Commissioner Bradford:

We wish to submit the following Form filing for Individual, Accident and Health for use in Arkansas.

This filing has been submitted to or is exempt from filing in our domiciliary state of Connecticut.

Policy Form(s) and Endorsement(s) Submitted:

Form Title:	Summary of coverage
Form No.:	GR-11741-SOC 06/09
Edition Date:	
Form Type:	Certificate Amendment, Insert Page, Endorsement

We trust with the enclosed information, you will be able to review our filing and grant an approval. If you have any questions, please contact the undersigned. Thank you in advance for your help and attention to this matter.

Mr. John Ciesielski
Product and Regulatory Affairs Manager

Phone: 860-279-1282
Fax: 860-952-2069
Email: CiesielskiJW@Aetna.com

Explanation of Variable Material

Form GR-11741-SOC (06/09)
Comprehensive Medical Expense Insurance Summary of Coverage

General Explanation

Variability, as indicated by bracketed material, is required so that only the appropriate information will be reflected based upon the plan of benefits requested by the Policyholder.

The standard language of the provision may be revised, as needed, to accurately reflect future changes. However, any change made to the language will not result in a departure from the intent and purpose of the provision and will be in full compliance with any applicable state laws and regulations.

Connective words and phrases, which serve the grammatical purpose of meaningful continuity and do not affect the description of the payment of benefits or other terms or conditions of the group policy, may vary as the sense demands.

Form GR-11741-SOC

Pages 1-8
Any dollar amount, percentage, or duration included within brackets may be varied within the range indicated.

Inpatient Hospital Copay and Deductible, Calendar Year Deductible, Hospital Emergency Room Copay, Individual Deductible, Family Deductible Provisions may be varied to reflect the particular plan specifications offered under the Policy.

Page 2
The Calendar Year Deductible may be combined or applied separately to Preferred and Non-Preferred Care Expenses. If combined, the bracketed reference will be omitted.

Page 2
The list of Preferred Care Expenses to which the Calendar Year Deductible is not applicable may be expanded, or may be omitted.

Page 2
If a common deductible is applicable to Prescription Drugs and other medical expenses, the bracketed reference will be omitted.

Page 6
The reference to an integrated deductible will be included only when the plan is a high-deductible plan. Otherwise, it will be omitted.

Page 9
The Payment Limits may be combined or applied separately to Preferred and Non-Preferred Care Expenses. If combined, the bracketed sentence in the first paragraph will be omitted.

Summary of Coverage

This Summary of Coverage is attached to and forms part of your Policy. The benefits shown in this Summary of Coverage are available for the persons listed in the Policy.

Health Expense Coverage For You and Your Dependents

The Policy spells out the period to which each maximum applies. These benefits apply separately to each covered person. All maximums included in this Policy are combined maximums between Preferred and Non-Preferred Care, unless stated otherwise. Read the coverage section in your Policy for a complete description of the benefits payable.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the Policy:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

Comprehensive Medical Expense Coverage

Utilization and Preservice Review Procedures

Certain procedures, admissions, services, supplies and treatments and certain other types of care must be certified as necessary if full benefits are to be available under the Policy.

The Policy lists the procedures, services, supplies and treatments which must be certified, describes the other types of care affected and gives you details on how to obtain certification and avoid a reduction in benefits payable.

Certification for Certain Procedures/Treatments Excluded Amount: [$400].

The Benefits Payable

After any applicable deductible, the Health Expense Benefits payable under this Policy in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be described later in the Policy. Benefits may vary depending upon whether a Preferred Care Provider is utilized. A Preferred Care Provider is a health care provider who has agreed to provide services or supplies at a "negotiated charge." A copy of a Directory which lists these health care providers is available on-line at www.aetna.com/docfind/custom/advplans, or may be requested by calling 866-565-1236.

[Deductible Amounts

	Individual	Family
Calendar Year Deductible:		
Preferred Care	[$0-8,000]	[$0-24,000]
Non-Preferred Care	[$500-10,000]	[$1,000-30,000]

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[[The Calendar Year Deductible applies separately to Preferred and Non-Preferred Care Expenses.] [The Calendar Year deductible is not applicable to Preferred Care expenses.] [The Calendar Year deductible is not applicable to Preferred Care only for:

Urgent Care Facility
Infusion Therapy Home or Physician Office
Infusion Therapy Outpatient Facility
Physician's services for office visits to Non-Specialists
Physician's services for office visits to Specialists
Preventive Health Expenses
Routine screening for cancer expenses
Gynecological Examinations/Mammograms
Hearing Aids
Generic Drugs

[Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the Calendar Year.]

[Once [2, 3] members of the family each meet their individual Calendar Year deductibles, from then on each other member of the family will be considered to have met their deductible for that Calendar Year.]

[A separate deductible applies to prescription drugs and medicines.]]]]

[Inpatient Hospital Copay and Deductible

[An Inpatient Hospital **Copayment** is an amount you are required to pay when you or a covered dependent is confined as an inpatient in a **hospital**. A **copayment** is a specified dollar amount required to be paid by you at the time you receive a covered service from a **[preferred] provider**.

[An Inpatient Hospital **Deductible** is a specified dollar amount for which no benefit is paid when you or a covered dependent is confined as an inpatient in a **hospital**.]

These Inpatient Hospital [**copayments]** [and] [**deductibles]** are in addition to any other [**copayments] [**and] **[deductibles**] applicable under this plan. They apply to each confinement as an inpatient in a **hospital.** If your confinement as an inpatient in a **hospital** is separated by less than 48 hours (regardless of cause), only one Inpatient Hospital [**copayment]** [or] [**deductible]** will apply. Not more than three Inpatient Hospital [**copayments]** [or] [**deductibles**] will apply for each facility type during a [calendar] year.]

[Covered expenses applied to the Inpatient Hospital deductible cannot be applied to any other **deductible** required in your plan. Likewise, covered expenses applied to your plan's other **deductibles** cannot be applied to meet the Inpatient Hospital deductible].]

If shown in your Summary of Coverage, this is the amount of Inpatient Hospital expenses you pay for each **Hospital** confinement of a Covered Person. Not more than 3 Inpatient Hospital Deductibles will apply to all confinements of a Covered Person in any one calendar year.

The Inpatient Hospital Deductible will only be applied once to all **Hospital** confinements, regardless of cause, which are separated by less than 10 days.

Expenses used to meet the Inpatient Hospital Deductible cannot be used to meet any other applicable **Deductible**. Expenses used to meet any other applicable **Deductible** cannot be used to meet the Inpatient Hospital Deductible.

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Calendar Year **Deductible**

This is the amount of Covered Medical Expenses you pay each calendar year before benefits are paid. There is a calendar year Deductible that applies to each Covered Person.

Hospital Emergency Room **Copay**

A separate Hospital Emergency Room **Copay** applies to each visit for emergency care, by a Covered Person in a **Hospital**'s emergency room unless the Covered Person is admitted to the **Hospital** as an inpatient within 24 hours after a visit to a **Hospital** emergency room.]

[Individual Deductible
The individual **deductible** is the amount of [**Preferred**] [**Non Preferred**] covered expenses you must incur in a [calendar] year before benefits are paid. For purposes of this plan, an individual means a single covered person enrolled for self only coverage.]

[**Family Deductible**
The family **deductible** is the amount of [**Preferred**] [or] [**Non Preferred**] covered expenses that you and your covered dependents must incur in a [calendar] year before benefits are paid during the [calendar][plan] year for any family members. For purposes of this plan, a family means a covered person enrolled with one or more dependents. The family **deductible** can be met by one family member, or a combination of family members.]

[Covered expenses that are subject to the d**eductible** include **prescription drug**, dental, vision and hearing expenses provided under the [Medical] [**Prescription drug**] [Dental] [Vision] [Hearing] Plans.]

If any expense is covered under one type of Covered Medical Expense, it cannot be covered under any other type.

Payment Percentage

The Payment Percentage applies after any copay or deductible amounts, unless otherwise specified above.

Preferred Care		**Non-Preferred Care**
For Hospital Expenses		
Inpatient Coverage		
[50-100%]		[50-100%]
	or	
[$0-100 inpatient hospital copay, thereafter 50-100%]		[$0-200 inpatient hospital deductible after calendar year deductible, thereafter 50-100%]
Outpatient Coverage		
[50-100%]		[50-100%]
	or	
[$0-100 per visit copay, thereafter 50-100%] **[(Waived if admitted)]**		[$0-200 per visit deductible after calendar year deductible, thereafter 50-100%]

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Preferred Care	Non-Preferred Care
Emergency Room [50-100%] **or** [$0-400 per visit copay, thereafter 50-100%] **[(Waived if admitted)]**	[50-100%] [$0-400 per visit deductible thereafter 50-100%]
Urgent Care Facility [50-100%] Or [$0-100 per visit copay, thereafter 50-100%]	[50-100%]
Skilled Nursing Facility Expenses* [50-100%] * In lieu of hospital.	[50-100%]

Preferred Care and **Non-Preferred Care** Calendar Year Maximum: [30-120] days

Home Health Care Expenses* [50-100%] *In lieu of hospital.	[50-100%]

Preferred Care and **Non-Preferred Care** Calendar Year Maximum: [30-60] visits

§ **Infusion Therapy** *Home or Physician Office* [$0-50 copay per visit, thereafter 50-100%]	[50-100%]
Infusion Therapy *Outpatient Facility* [50-100%] *Applicable to non preferred care: administration, nursing, equipment, supplies-the maximum benefit of [$0 -$50] per visit and amounts over allowable do not apply to the Payment Limit. Drugs are paid according to **Recognized Charge** [50-100%].	[50-100%]
Hospice Expenses [50-100%]	[50-100%]

Preferred Care and **Non-Preferred Care** Lifetime Maximum: [$10,000]

Outpatient Surgical Expenses [50-100%]	[50-100%]
Physicians' Services **Office Visits (**non-surgical) to Non-Specialist (internist, general physician, family practitioner, or pediatrician). **Office Visits to Non-Specialists** [$0-50 copay per visit for the first 1-5 visits, thereafter 50-100%] Or	[50-100%]

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[$0-50 copay per visit, thereafter 70-100%]

Preferred Care	**Non-Preferred Care**
Office Visits to Specialists [$0-50 copay per visit for the first 1-5 visits, thereafter 50-100%] Or [$0-50 copay per visit, thereafter 70-100%]	[50-100%]
Other Physicians' Services [50-100%]	[50-100%]

Preventive Health Expenses

For Covered Dependent's to Age 18:

[$0-50 copay per visit, thereafter 100%]	[50-100%]

Preferred Care and **Non-Preferred Care** Maximum: [$200]

For Policyholder or the Covered Dependent's Age 18 or over:

[$0-50 copay per visit, thereafter 100%]	[50-100%]

Preferred Care and **Non-Preferred Care** Maximum: [$200]

Routine Screening for Cancer

For age and frequency limits applicable to Routine Cancer Screening coverage, refer to the Policy.

Gynecological Exams/Mammogram [$0-50 copay per visit, thereafter 70-100%]	[50-100%]
Other Cancer Screenings [100%]	[50-100%]

[Includes one annual screening mammogram; one routine gynecological exam per Calendar Year, including a Pap smear and related services; colorectal screening in accordance with the latest screening guidelines issued by the American Cancer Society; and one prostate antigen test (PSA) once each Calendar Year for males age 40 or older.]

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[Prescription Drug Benefits (Out of Hospital)

*[Retail and Mail Order Pharmacy]**	*[Retail and Mail Order Pharmacy]**
[$0-1,000] Individual Calendar Year deductible [(Not applicable to generic drugs).]	[$0-1,000] Individual Calendar Year deductible [(Not applicable to generic drugs).]
[Integrated Medical/RX deductible	Integrated Medical/RX deductible]
Generic Drugs [$0-50 copay per prescription or refill, thereafter 50-100%]	[$0-50 deductible per prescription or refill, thereafter 50-100%]
Formulary brand name drugs [50%] Or [$0-40] per prescription or refill	[$0-50 deductible per prescription or refill, thereafter 50-100%] [$0-50 deductible per prescription or refill, thereafter 50-100%]
[Not covered]	[Not covered]
[Non-formulary brand name drugs:] [50%] Or [$0-40] per prescription or refill	[$0-50 deductible per prescription or refill, thereafter 50-100%] [$0-50 deductible per prescription or refill, thereafter 50-100%]
[Not covered]	[Not covered]

Preferred Care and **Non-Preferred Care** Calendar Year Maximum: [$2,500]

*Not more than up to a [30-90] day supply from a participating pharmacy.
**Not more than up to a [30-90] day supply from a non-participating pharmacy.

*Mail Order Pharmacy****	*Mail Order Pharmacy*
[50-100%]	Not Covered

Preferred Care and **Non-Preferred Care** Calendar Year Deductible: [$0-1,000]

Copay: [2X-3X] the copay for Retail Pharmacy.

***Limited to not more than a [31-90] day supply.

Preferred Care	**Non-Preferred Care**
[[Self]-Injectables: The copay applicable to self-injectable drugs is described below. The benefit Percentage, Calendar Year Maximum and limitations as to supply amounts are the same as for other types of drugs from a Retail Pharmacy:	Not Covered
Initial prescription or refill	

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Not on Formulary: [10-50%] of
The negotiated charge between Aetna
And the preferred pharmacy [vendor
or supplier designated by Aetna]

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Preferred Care **Non-Preferred Care**

On Formulary: [10-50%] of
The negotiated charge between Aetna
And the preferred pharmacy [vendor
or supplier designated by Aetna]

[The [Deductible amount] will not apply
to covered benefits for [chronic] [and]
[preventive] prescription drug expenses.

[These drugs include those used to treat
[hypertension, hyperlipidemia, diabetes,
asthma, osteoporosis, depression, and
heart disease]. The [chronic] [and]
[preventive] prescription drug list is
available upon request by the Covered Person
or may be accessed at the ALIC website,
at [www.aetna.com].
The list is subject to change]

Prescription Refill:
Not on Formulary: [10-50%] of
The negotiated charge between Aetna
And the preferred pharmacy [vendor
or supplier designated by Aetna]

On Formulary: [10-50%] of
The negotiated charge between Aetna
And the preferred pharmacy [vendor
or supplier designated by Aetna.]]]

Preferred Care **Non-Preferred Care**

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Durable Medical Equipment
[50-100%] [50-100%]

Preferred Care and **Non-Preferred Care** Annual Maximum: [$1,000-5,000]

Professional Ambulance Expenses
[50-100%] [50-100%]

Preferred Care and **Non-Preferred Care** Per Trip Maximum: [$1,000-5,000]

Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Therapy and Spinal Manipulation
[50-100%] [50-100%]

Preferred Care and **Non-Preferred Care** Per Visit Maximum: [$0-25]
Preferred Care and **Non-Preferred Care** Calendar Year Maximum Visits: [24]
Preferred Care and **Non-Preferred Care** Calendar Year Maximum: [$600]

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Pregnancy Coverage

[50-100%] [50-100%]

Preferred Care and **Non-Preferred Care** [$0-2,000] copayment per inpatient hospital maternity related admission.

[Mental Health DRAFTING NOTE: OMIT IF NO STATE MANDATE
[50-100%] [50-100%]
[Not Covered]]

[Hearing Aid
One hearing aid per ear every 36 months up to $200 per hearing aid (includes repairs). Batteries and auxiliary equipment are excluded. [Deductible and coinsurance do not apply.] Not covered for first 12 months.]

Organ Transplants
[50-100%] [50-100%]
[Not Covered]

All Other Covered Medical Expenses
The Payment Percentage shown below as to all other covered medical expenses not specified above:
[50-100%] [50-100%]

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Payment Limits
These limits apply to Covered Medical Expenses. [These limits apply separately to Preferred and Non-Preferred Care.] [Expenses which are Excluded Amounts for failure to precertify certain procedures/treatments, NOTE: OMIT IF PREGNANCY NOT MANDATED [expenses which are applied to any Pregnancy and Maternity Benefits copay amounts,]and expenses that apply to copay amounts for other expenses] will not count toward these limits.

Payment Limit which Applies to Expenses for a Covered Person
When a Covered Person's Covered Medical Expenses for which no benefits are paid reach [$2,000-12,500] in a Calendar Year, benefits will be payable at 100% for all of the Covered Person's Covered Medical Expenses to which this limit applies and which are incurred during the rest of that Calendar Year.

Payment Limit which Applies to Expenses for a Family
When a family's Covered Medical Expenses for which no benefits are paid reach [$4,000-37,500] in a Calendar Year, benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred during the rest of that Calendar Year.

[Payment Limit which Applies to Expenses for a Covered Person
When a Covered Person's Covered Medical Expenses for which no benefits are paid reach [$2,000-12,500] in a Calendar Year for Preferred Care and [$2,000 -12,500] in a Calendar Year for Non-Preferred Care, benefits will be payable at 100% for all of the Covered Person's Covered Medical Expenses to which this limit applies and which are incurred during the rest of that Calendar Year.]

[Payment Limit which Applies to Expenses for a Family

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When a family's Covered Medical Expenses for which no benefits are paid reach [$4,000 -37,500] in a Calendar Year for Preferred Care and [$4,000-37,500] in a Calendar Year for Non-Preferred Care, benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred during the rest of that Calendar Year.]

Private Room Limit	The institution's semiprivate rate.
Lifetime Maximum Benefit	[$25,000-5,000,000]

Note: Lifetime Maximum cross applies to preferred and non preferred care

Adjustment Rule

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If, for any reason, a Covered Person is entitled to a different amount of coverage, coverage will be adjusted as of its effective date.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised Policy provisions. In other words, there are no vested rights to benefits based upon provisions of this Policy in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under the Policy. Requests for amounts of coverage other than those to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

The insurance described in this Summary of Coverage will be provided under Aetna Life Insurance Company Policy Form GR-11741.

KEEP THIS SUMMARY OF COVERAGE WITH YOUR POLICY

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Life, Accident & Health, Annuity, Credit Transmittal Document

1.	**Prepared for the State of**	Arkansas

2.	**Department Use Only**
	State Tracking ID

3.	**Insurer Name & Address**	**Domicile**	**Insurer License Type**	**NAIC Group #**	**NAIC #**	**FEIN #**	**State #**
Aetna Life Insurance Company 151 Farmington Avenue Hartford CT 06156		CT		001	60054	06-6033492	

4.	**Contact Name & Address**	**Telephone #**	**Fax #**	**E-mail Address**
John Ciesielski 151 Farmington Avenue, Mail Stop RW61 Hartford CT 06156		860-279-1282	860-952-2069	CiesielskiJW@Aetna.com

5.	**Requested Filing Mode**	☒ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	**Company Tracking Number**	AH AR0110501F01	
7.	☐ **New Submission** ☐ **Resubmission**	Previous file # _____	
8.	**Market**	☒ Individual ☐ Franchise	
		Group	☐ Small ☐ Large ☐ Small and Large ☐ Employer ☐ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____
9.	**Type of Insurance**	H16I Individual Health - Major Medical	
10.	**Product Coding Matrix Filing Code**	H16I.005A Individual - Preferred Provider (PPO)	
11.	**Submitted Documents**	☐ **FORMS** ☐ Policy ☐ Outline of Coverage ☐ Certificate ☐ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☒ Schedule of Benefits ☐ Other: _____ ☐ **RATES** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreement ☐ Statement of Variability ☐ Certifications ☐ Actuarial Memorandum ☐ Other: _____	

12.	**Filing Submission Date**	June 18, 2009
13.	**Filing Fee (If required)**	Amount _____ Check Date _____ Retaliatory ☐ Yes ☒ No Check Number _____
14.	**Date of Domiciliary Approval**	not applicable
15.	**Filing Description:**	
	Revised summary of coverage for Individual advantage plans	

16.	**Certification (If required)**

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name John Ciesielski Title Product and Regulatory Affairs Manager

Signature John W Ciesielski Date June 18, 2009

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	AH AR0110501F01
This filing corresponds to rate filing company tracking number	

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
01	Summary of coverage	GR-11741-SOC 06/09	☒ Initial ☐ Revised ☐ Other _____	
02			☐ Initial ☐ Revised ☐ Other _____	
03			☐ Initial ☐ Revised ☐ Other _____	
04			☐ Initial ☐ Revised ☐ Other _____	
05			☐ Initial ☐ Revised ☐ Other _____	
06			☐ Initial ☐ Revised ☐ Other _____	
07			☐ Initial ☐ Revised ☐ Other _____	
08			☐ Initial ☐ Revised ☐ Other _____	
09			☐ Initial ☐ Revised ☐ Other _____	
10			☐ Initial ☐ Revised ☐ Other _____	
11			☐ Initial ☐ Revised ☐ Other _____	